

## DEPARTMENT OF HEALTH AND FAMILY SERVICES

Division of Supportive Living

DSL-458 (Rev. 02/2001)

## STATE OF WISCONSIN

SOS Desk (608) 266-9198

Completion of this form meets the requirements of the State / County contract specified under the Wisconsin Statutes.

S. 46.031(2)(c)(2).

## HSRS ALCOHOL AND OTHER DRUG ABUSE MODULE

## REGISTRATION - Screen A3 N, U or I (Module Key: )

1 Worker ID		2 Social Security Number			3 Client ID		
4a Last Name		4b First Name		4c MI	4d Suffix	5 Birthdate (mm / dd / yyyy) ____/____/____	6 Sex F / M
7a Hispanic/Latino Y = Yes N = No	7b Race (Circle up to 5) A = Asian B = Black or African American P = Native Hawaiian or Pacific Islander I = American Indian or Alaska Native W = White		8 Client Characteristics		9 Start Date ____/____/____	10 Closing Date ____/____/____	11 Co-dependent / Collateral Y = Yes N = No
13 Education at Time of Admission	14 Family Relationship	15 Brief Service Y = Yes N = No	16 Employment Status	17 Employment History	18 Pregnant at Time of Admission Y = Yes N = No	19 Disabilities (Circle up to three) 1 Developmental Disability    3 Sensory Disability    5 Frail Elderly 2 Physical Disability    4 Mental Illness    6 None	
20 Diagnosis	21 Case Review Date ____/____/____	22 Family ID		23 Local Data		24 Special Project Reporting	
If "Yes" in fields 11 or 15, skip fields 25-29				25a Primary		25b Secondary	
Substance Problem				25c Tertiary		26 At Discharge	
Usual Route of Administration				27a Primary		27b Secondary	
Use Frequency				28a Primary		28b Secondary	
Age of First Drug Use or Alcohol Intoxication				29a Primary		29b Secondary	
				29c Tertiary			

## SERVICES - Screen A4 (Module Key: )

Prog. No.	30 SPC Sub Prog	31 SPC Start Date	32 Provider Number	33 Days of Care	34 Other Units	35 Delivery Date mm   yyyy	36 SPC End Date	37 SPC End Reason	38 Closing Status A   F   E			39 Target Group	40 SPC Review Date mm   yyyy	

## OPTIONAL DATA - Screen 18 (Module Key: )

Street Address		City	State	Zip Code	County	Telephone Number ( )
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Shaded areas are optional.

## HSRS ALCOHOL AND OTHER DRUG ABUSE MODULE CO-DEPENDENT / COLLATERAL OR BRIEF SERVICES

### REGISTRATION - Screen A3 N, U or I

1 Worker ID			2 Social Security Number			3 Client ID			
4a Last Name			4b First Name		4c MI	4d Suffix	5 Birthdate (mm / dd / yyyy)  ____/____/____	6 Sex  F / M	
7a Hispanic / Latino  Y = Yes N = No	7b Race (Circle up to 5)  A = Asian B = Black or African American P = Native Hawaiian or Pacific Islander I = American Indian or Alaska Native  W = White		8 Client Characteristics    		9. Start Date  ____/____/____		10 Closing Date  ____/____/____		11 Co-dependent / Collateral  Y = Yes N = No
12 Referral Source	15 Brief Service  Y = Yes N = No	20 Diagnosis	21 Case Review Date  ____/____/____		22 Family ID		23 Local Data		

### SERVICES - Screen A4 (Module Key: )

Prog. No.	30 SPC Sub Prog.	31 SPC Start Date	32 Provider Number	34 Other Units	35 Delivery Date mm   yyyy	36 SPC End Date	39 Target Group	40 SPC Review Date mm   yyyy

### OPTIONAL DATA - Screen 18 (Module Key: )

Street Address	City	State	Zip Code	County	Telephone Number (   )
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Shaded areas are optional.